ARKANSAS DEPARTMENT OF HUMAN SERVICES
LONG TERM CARE APPLICATION FOR ASSISTANCE

What services are you requesting?

Si necesita este formulario en Español, llame al 1-800-482-8988 y pida la versión en Español

☐ **Nursing Facility** ☐ **ALF** ☐ **EC** ☐ **AAPD Waiver** ☐ **PACE** ☐ **DDS Waiver**

If you need this material in a different format, such as large print contact your DHS county office.

1. I am a resident of Arkansas: Yes ☐ No ☐ 2. I am: 65 years of age or older ☐ Blind ☐ Disabled ☐

3. My full name is: _____ Race _____ Sex _____
Last First Middle

4. My current address is: _____
Physical Address City State Zip County

_____
Mailing Address (P.O. Box) City State Zip County

My former address was: _____
Mailing Address City State Zip County

I have lived at my current address for: _____ years.

5. My telephone number is: _____ 6. I was born on: _____
Month Day Year

7. _____ _____ I was born in: _____
Social Security Number Medicare Number City or County

_____ _____ _____
Railroad Ret. Number VA Claim Number State or Country

8. I am a U.S. Citizen: Yes ☐ No ☐ 9. I am a lawfully admitted Alien: Yes ☐ No ☐

10. I am: Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐

Complete Questions 11 – 15 ONLY if you have a Spouse

11. My spouse's name is: _____
Last First Middle

12. My spouse's address is: _____
Street or Route No. City State Zip County

13. My spouse's telephone number is: _____ 14. My spouse was born on: _____
Month Day Year

15. _____ _____ _____ _____
Spouse's Soc. Sec. No Spouse's Medicare No. Spouse's Railroad Ret. No. Spouse's VA Claim No.

16. I and my spouse have income from the following: (Check (√) Yes or No. If yes enter the amount and how often the income is received).

	MYSELF				MY SPOUSE			
SOURCE OF INCOME	YES	NO	AMOUNT	HOW OFTEN	YES	NO	AMOUNT	HOW OFTEN
Retirement Benefits								
Social Security Benefits								
SSI								
Veteran's Benefits								
Railroad Retirement								
Civil Service Benefits								
Interest/Dividends								
Insurance								
Money From Trusts								
Mineral Rights/Oil Leases								
Rental								
Cash Contributions								
Unemployment Benefits								
Worker's Compensation								
Employment/Work								
Farming/Self Employment								
Deposits by Others for Me								
Other								

17. I or my spouse have received SSI in the past: Yes ☐ No ☐ If Yes, when _____

18. I or my spouse expect a change in income: Yes ☐ No ☐ If Yes, explain. _____

19. I or my spouse own a home. Yes ☐ No ☐
If yes, my home is occupied by my spouse and/or dependent relatives. Yes ☐ No ☐

Address of Home Equity Value

I or my spouse formerly owned homes in:

City, County and State

City, County and State

20. I or my spouse own real property, (land or buildings), other than my home. Yes ☐ No ☐
If yes, complete the following:

Address of Property Equity Value

Address of Property Equity Value

I or my spouse formerly owned real property other than my home in:

City, County and State

21. I or my spouse have sold/deeded/given away a home or other real property:

To Whom

22. I or my spouse retain life estate, dower, curtesy, inheritance or other interest in a home or other property

Location of Property (City, County, State) Type of Interest Value

23. I or my spouse own personal property such as cars, trucks, tractors or farm machinery, trailers, boats, etc.: (If more than three, please list on a separate sheet)

Item (Make, Model, and Year) Equity Value

Item (Make, Model, and Year) Equity Value

Item (Make, Model, and Year) Equity Value

24. I or my spouse own livestock (cattle, poultry, catfish, minnows, crickets, worms, etc.)
Yes ☐ No ☐ If yes, complete the following:

Type of Livestock and Number Owned Value

25. I or my spouse have the following assets. (Check (√) Yes or No. If yes, enter the amount/value, location of the asset, and name of joint owner, if any.)

TYPE	YES	NO	AMT/VALUE	LOCATION OF ASSET	NAME OF JOINT OWNER
Cash					
Checking Account					
Savings Account					
Other Savings (Certificates, etc.)					
Promissory Notes					
Stocks					
Bonds					
Patient Fund Account					
Mortgage					
Burial Plot/Crypt					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other					

26. I or my spouse have additional income and/or property (real or personal) that I was unable to list under items 16 through 23.
Yes ☐ No ☐ If yes, record your answer(s) on a separate sheet.

27. I or my spouse have other resources (real or personal property) that are being held for me by another individual.
Yes ☐ No ☐ If yes, complete the following:

Type of Resource Location of Resource Amt/Value

Type of Resource Location of Resource Amt/Value

28. I or my spouse have hospital/medical insurance coverage. Yes ☐ No ☐ If yes, complete the following:

Name and Address of Insurance Company Policy No.

29. I have unpaid medical expenses from the past three (3) months. Yes ☐ No ☐

30. I, or someone in my household, would like to learn to read, or to read better. Yes ☐ No ☐

31. Do you have Long Term Care Insurance? Yes ☐ No ☐

- I understand that I must help establish my eligibility by providing as much of the requested information as I can.
- I authorize the Department of Human Services to make any investigation concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I understand that no person may be denied long term care assistance or other Medicaid assistance on the grounds of race, color, sex, national origin or disability.
- I understand that I may request a hearing before the state agency representative if a decision is not reached on my case within the appropriate time limit or if I disagree with the decision reached.
- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I authorize the Department of Human Services to examine all records of mine, or records of those receiving or having received Medicaid benefits through me, for the purpose of investigating whether or not any person may have committed Medicaid fraud or for use in any legal, administrative or judicial proceeding.
- I understand that I must provide my Social Security Number as a condition of my eligibility; and I understand that this number may be used by the Agency without my express permission in a computer match to obtain information relative to my eligibility for assistance from the Social Security Administration, Department of Workforce Services, Internal Revenue Services, or other agencies.
- ASSIGNMENT OF MEDICAL SUPPORT. I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS on my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.
- I understand the requirement to disclose, in my application for Long Term Care services, information regarding any interest that I or my community spouse may have in an annuity.
- I understand the requirement to name the state as a remainder beneficiary in which I or my spouse is the annuitant.
- If you have questions or problems regarding your application or care, please call your State Long Term Care Ombudsman at 501-682-8952.
- IMPORTANT ESTATE RECOVERY NOTICE:
  If you receive Medicaid in a nursing facility, ICF/MR facility, or under a home and community based waiver program, the total amount of the Medicaid benefits paid on your behalf will be a debt to DHS and may be recovered from your estate or from the grantee of a beneficiary deed after your death. Your estate is the property you own at the time of your death. DHS will not make a claim against your estate while you are living. DHS will not make a claim against your estate after your death if your spouse is still living, or if you have dependent children under age 21 or blind or children with disabilities. DHS will collect the debt, if any, by filing a claim in your estate. Collection may not be made if it is not cost effective to DHS or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for your heirs, if that income is limited, or if there are other compelling circumstances.
  CERTIFICATION: I HAVE READ THE ABOVE STATEMENTS AND I AGREE TO THEIR PROVISIONS.

- FOR LONG TERM CARE FACILITY RECIPIENTS/APPLICANTS ONLY: After reviewing the alternatives to nursing facility placement available through the Department of Human Services, I understand that I am choosing to be served in a nursing facility.
- I understand that if I am admitted to a nursing facility based on conditional Medicaid approval and my Medicaid case is denied, I, or my family, will be responsible for any indebtedness while in the nursing facility.
- I understand that this form is signed subject to penalties for perjury, I understand that if I receive assistance to which I am not entitled as a result of withholding information or providing inaccurate information, such assistance will be subject to recovery by the Department of Human Services and I may be subject to prosecution for fraud and fined and/or imprisoned.

Witness (if signed by mark)/Date	Applicant, Guardian, or Authorized Rep's Signature
Address of Witness/Telephone Number	Date / Telephone Number
Name of Person Who Helped Complete Form/Date	Guardian or Authorized Rep.'s Address